

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2012
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00106201.</p> <p>Complaint IN00106201-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 23, 2012</p> <p>Facility number: 012180 Provider number: 012180 AIM number: N/A</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: Residential: 67 Total: 67</p> <p>Census payor type: Other: 67 Total: 67</p> <p>Sample: 5</p> <p>Rittenhouse Senior Living of Michigan City was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00106201.</p> <p>Quality review 4/25/12 by Suzanne Williams, RN</p>		R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

116H11

If continuation sheet 1 of 1